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Interactional Alarms: Experts' Framing of Health Risks in Live Broadcast News Interviews

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Abstract

This study examined how experts frame health risks in real-time interactions with journalists. Though there is evidence that experts influence media framing of health risks, the ways they respond to journalists' agendas in real-time interactions has yet to be explored. This paper examines instances of risk assessment extracted from a corpus of news interviews to determine how expert assessments were requested and provided. The analysis reveals that experts rarely deliver their assessments neutrally but rather treat these exchanges as opportunities for framing or reframing the topic. Their framing is shown to be responsive to journalistic agendas and to those who experts understand to be accountable when their assessment is elicited. These findings suggest ways in which news interviews can be useful in health communication. The implications for experts, journalists and public information officers who plan to use interviews for this purpose are discussed.

1. Introduction

This study examined how experts frame health risks in real-time interactions with journalists. The news media play a critical role in communicating health risks to the general public (Wellcome Trust, 2016) and in shaping their understanding, attribution of responsibility and preventive behaviours (Harvey & Koteyko, 2013). Though risk alerts are often premised on the authority of expert sources (Vasterman & Ruigrok, 2013; Raupp, 2014)

journalists are often faulted for amplifying and dramatizing health risks and creating undue public anxiety (Tang & Rundblad, 2015). Health media messages are usually examined in edited reports in which experts are cited or used in a sound-bite that supports the planned framing of the news story (Verhoeven, 2010). In contrast, a news interview is unscripted, thus allowing news sources to take part in framing the emerging account (Clayman & Heritage, 2002). News interviews hence afford a unique setting for exploring the co-production of health risk alerts by experts and journalists.

A number of studies have examined the framing of news reports by the experts that have been interviewed but these studies invited in the main assessments of past encounters. They show that journalists often set the agenda in advance but that experts identify their input into the framing of news items (Albaek, 2011). Their influence have been shown to reflect their ability to play by the media rules, which is often acquired through previous training or media encounters (Wien, 2014). These findings are useful for understanding interactions between experts and journalists. However, because they are retrospective studies, they cannot engage in "the media game" (Holland, Blood, Imison, Chapman, & Fogarty, 2012) as played out in actual encounters. By researching live broadcasts, this study examined how experts accommodate their health risk assessments to journalistic agendas, and how the framing of health risks takes emerges interactionally. Rather than analysing past encounters or edited reports, the framing of health risk assessments is examined as they are delivered and take shape.

2. Framing health risks

Media framing is a discursive strategy by which journalists identify and package relevant information for their audiences and set a new event in a familiar context and language (Scheufele, 1999). Typically, framing promotes "a particular problem definition, causal

interpretation, moral evaluation and/or treatment recommendation" for the issue at hand (Entman, 1993, p.52). For example, the framing of obesity in news coverage was found to shift between the attribution of moral responsibility to obese persons, the faulting of social and economic forces, the promotion of education for life-style changes or the rejection of the medicalization of obesity altogether (Lawrence, 2004; Atanasova & Koteyko, 2016). By implying the cause and accountable persons, each frame suggests different recommendations or policies each targeting in the main citizens, health authorities or industry (Khayatzadeh-Mahani, Ruckert, & Labonté, 2017).

Health news frames are typically studied as recurrent typologies of representation that can be identified and compared across news corpora. Previous studies have found shifts between alarmist and reassuring framings (Vasterman & Ruigrok, 2013) and a focus on risk factors or prevention (Liu, Ley, & Brewer, 2011), either in the course of a specific crisis (Vasterman & Ruigrok, 2013) or during extended coverage (Kang, Gearhart, & Bae, 2010). This typological, "list of frames" approach (Tankard, 2001) is useful when attempting to identify general patterns of framing but does not serve to determine how a health risk is framed in a particular report or as a function of its media format, genre and audiences (Bakir, 2010).

Another gap in the literature pertains to the ways in which journalists and health experts collaborate despite differences in reporting norms. Public information officers (PIOs) in hospitals or public health institutes tend to see the mass media as a useful way to disseminate health advice and alerts (Rim, Hong Ha, & Kiousis, 2014; Roberts & Veil, 2016). However, there is a clear and well-documented tension between journalists and their expert sources. Whereas health authorities use the media to reach the broadest audience possible, journalists are concerned with highlighting the elements they perceive as newsworthy and relevant to their readers (Riesch & Spiegelhalter, 2011; Roberts & Veil, 2016). Previous studies have

shown that journalists and health professionals understand and communicate risk differently in terms of the information that is perceived as relevant and newsworthy (Riesch & Spiegelhalter, 2011). However, not much is known about the ways that experts respond to journalistic frames.

Rather than searching for frames as predefined constructs or schemas, this study examined framing as an activity that experts are engaged with and structure to respond to local agendas. Previous studies of interactions between experts and journalists have dealt with these interactions retrospectively rather than directly. Health journalists who have been queried about their newsgathering practices often mention their reliance on expert sources but identify themselves as responsible for framing this information for their audiences (Friedman, Tanner, & Rose, 2014; Tanner, Friedman, & Zheng, 2015). But even when risks are framed dramatically, the information cited was found to reflect the statements published in scientific papers or press releases (Riesch & Spiegelhalter, 2011; Rim et al., 2014; Sumner et al., 2016). While the involvement of experts in framing health risk have been demonstrated in previous research, this study explored how these frames are constructed in actual encounters.

News interviews, like press reports, are journalist-led but they give news sources opportunities to reshape media messages as they are produced. Interviewers are expected to control the agenda and have been shown to set it up in the opening, and when questioning interviewees (Greatbatch, 1986; Clayman & Heritage, 2002). Interviewees often shift the agenda or evade questions, but they have been shown to so without challenging the interviewers' roles. By requesting permission, explaining their digression, reformulating the question or confirming the interviewer's presuppositions, interviewees minimize the interactional conflict involved in topical shifts (Greatbatch, 1986; Clayman & Heritage, 2002; Weizman, 2008). Thus, the news interview allows for a study of how experts frame health risks but in ways that remain relevant to the topics of talk as defined by their hosts.

In looking at media frames as the product of talk this study departs from previous studies of interactional framing. Following Goffman (1974) frames have been examined as speech activities (e.g. lecturing, joking, storytelling, news reading) and framing as the indications provided by participants as to how their utterances should be understood. In contrast with interactive frames, media frames are usually studied as story-lines or schemas set up by journalists to resonate with their audiences' expectations about people, objects, events and settings in the world (Tannen & Wallat, 1987). Goffman's notion of framing has been widely applied in studies of broadcast interactions in studying activities such as questioning (Clayman & Heritage, 2002) and arguing (Hutchby, 2006).

This study differs in that it examines interaction for orientation towards conventional ways of framing news items. Applying Entman's framework (1993) but in an interactional setting, the delivery of health risk assessment was examined in exchanges discussing the definition of health problems, their causes or treatments. These exchanges were examined for framing devices that are typical of health risk reporting such as "scare statistics" (Harvey & Koteyko, 2013), attributions of precision and magnitude, and comparisons with conventional risks (Potter, Wetherell, & Chitty, 1991; Amberg & Hall, 2010). Whereas such wordings have been examined in press reports, here they were studied as used by experts to frame their assessments or respond to the framing of risks by their hosts.

In examining media frames as interactional products this paper contributes to the study of frame building in health communication and beyond. Frame building refers to how frames emerge through exchanges and negotiation between journalists and their sources over extended coverage periods (Scheufele, 1999; Vreese, 2005). Health communication research has demonstrated how input from experts, civic organizations or members of the public shape the framing of various topics. For example, the coverage of the 2009 influenza A (H1N1) outbreak as it developed have been shown to adopt the framing of cited experts (Vasterman

& Ruigrok, 2013). However, a study of the coverage of Alzheimer's disease during a 25-year period revealed a more nuanced trajectory in which stories have been shaped by patients, policy makers and celebrities as well (Kang et al., 2010). While frame building have been studied over time, this study explored how journalists and their sources build the framing of health topics interactionally where and when the news is produced and transmitted.

3. Data and Method

The data for this study is a corpus of 150 naturally occurring recorded and transcribed studio interviews conducted in Hebrew and broadcast (2009-2011) on the current affairs talk-show *London et Kirschenbaum* from 2009 to 2011 (Armon & Baram-Tsabari, 2016). The programme is aired on a national commercial channel in Israel (Channel 10). Co-hosted by two veteran journalists, Yaron London and the late Moti Kirschenbaum, this highbrow pre-primetime news magazine is one of Israel's key agenda-setting news broadcasts. Occasionally, the program invites scientific experts to discuss recent breakthroughs or science-related issues such as medicine or the environment. The program is a much sought-after venue for academic experts and their institutions, and is aimed to educated audiences perceived by the program team as loyal followers (Armon, Barel Ben-David, & Baram-Tsabari, 2017).

This study is part of a larger project in which these interviews were examined for the discursive strategies implemented by experts and journalists when handling the challenge of communicating scientific research to lay audiences. Scientists were shown to introduce their research stories to account for and select an adequate context for the findings they are asked to deliver, especially when confronting a very different storyline than the one prioritised by the presenters (Armon, 2016; Armon & Baram-Tsabari, 2016).

The present study focuses on cases where scientists or medical doctors have been asked to advise the public as general experts rather than only to report on their studies (Peters,

2014). Most interviewees were health experts with scientific credentials (n=46) who were introduced as clinicians (n=30) and/or as biomedical researchers (16). To examine how health risk assessments are constructed, the corpus was searched for instances in which experts were asked about incidence rates, risk factors, diagnostic issues or preventive measures in ways that responded to standard epidemiological definitions (Carneiro & Howard, 2011).[1] In that way, these instances have been taken as cases where the information was elicited in a form that was familiar to interviewees and that should have elicited a straightforward response. The search identified 147 instances of exchanges concerning health risks in 48 interviews. Although this corpus was drawn from a single program, the instances represent a variety of public health and scientific topics that experts are called upon to advise.

The local occasioning of risk assessments was examined in question and answer turns through a conversation analytical approach (Fox & Thompson, 2010). Interviewers' questions were examined for the type of responses they elicited (Clayman, 2016) and experts' responses were searched for evidence as to who and what they understood to be accountable in delivering their advice (Bolden & Robinson, 2011). The detailed transcription of exchanges incorporated observable pauses or overlaps between turns (Hepburn & Bolden, 2012), questions rephrases (Fox & Thompson, 2010) or unelicited accounts (Armon & Baram-Tsabari, 2016). These have been examined as evidencing sources of trouble or the agendas that experts identified as relevant when they delivered assessments (see appendix 1 for transcription notation).

[1] The codebook used for searching the transcripts for risk categories is available from the author.

4. Observations

a. Problem Definition

The following examples illustrate interactional exchanges in news interview openings that are normally used by journalists to frame the topic and define the issue at hand. Openings normally consist of a short headline that is designed to capture the audience's attention and draw it into the unfolding discussion, followed by relevant background and a lead into the talk that introduces interviewees (Clayman & Heritage, 2002). Interviews on health in this corpus often included an exchange in which interviewees have been asked about the incidence rate for the disease or syndrome discussed.

The exchanges concerning incidence rates were often treated differently by the interviewers and interviewees. The interviewers marked the elicitation and delivery of incidence rate as an "inserted sequence" (Schegloff, 2007); that is, an exchange that handles a subsidiary topic before the main business of the talk is engaged. As shown in examples 1-4, incidence rates were often not the topic of the talk but were elicited to mark the syndrome as relevant and newsworthy. However, the experts who responded did not limit themselves to the delivery or confirmation of incidence rates. Rather, they treated these exchanges as opportunities to put forward their definition of the problem.

Excerpt (henceforth ex.) 1 presents a case in which incidence rates are elicited and delivered as background information. It differs in this respect from examples 2-4 and is used here for comparison. The item from which the excerpt is drawn reported on a study on the incidence of cervical cancer among women from diverse ethnic origins in Israel. However, in this segment the interviewee is requested to provide the general incidence rate for the disease which is not the main news story:

ex.1. cervical cancer, 8.12.09

1 YL. how many women eh become affected by this disease
2 [°e::h annually°]

IE. [hhh. e:::h] in the ↑state of Israel the situation is more or less e:h stable the rate is more or less stable ↑around hundred and sixty hundred and eighty s->eh sick women per year new ones
(0.2)
YL. you e::[::h]
MK. [and] so what what what did you find in the study (0.4) that we ((did)) not know ↓already

The incidence rate is provided in a short response. The overlap and citing of the rate as the estimate that is currently available ("more or less"; Hebrew (henceforth, heb). *pakhot o' yoter*, l.3) and in its scientific form ("sick persons per year", heb. *kholim be'shana*, l.4-5) indicates that the type of information elicited was delivered by the interviewee as a standard value. Indeed, Kirschenbaum marks this business as finished before addressing the main topic of this interview; namely, the research conducted by the interviewee ("and so"; heb. *ve'-az*, l.8).

But while in ex.1 all speakers treated the exchange as delivering background, the elicitation of incidence rates in ex.2 is treated differently by the interviewers and the interviewee. This sequence is part of the introduction to an item that reported on a recently developed test to detect signs of pre-diabetes long before the symptoms are manifested. The interviewee is asked to provide the incidence rate of diabetes as background to the topic but he uses this as an opportunity to contextualise this topic:

ex 2. diabetes test, 20.9.10
YL. e:h ho->how ma:ny people in this country e::h are affected by diabetes?
(0.3)
IE. hh. we:::know about five hundred thousand (.) patients having diabetes (0.3) hh. but there are more than about five hundred thousand patients in a state that is called a state (0.3) h. ((that is)) pre-diabetic or preceding diabetes hh. tha::t are at risk (.) almost like that of the diabetic patients hh. regarding their tendency to develop brain strokes and heart ↓attacks
(0.6)
YL. [°Yes°]
MK. [Now] there are two types of diabetes (1.0) maybe you can tell us what they ↓are

The added information regarding pre-diabetic patients (l.4-7) was not elicited but is marked by the interviewee as an important supplement ("but"; heb. *aval*, l.4). By comparing

the rate of pre-diabetic to diabetic patients he uses their incidence to frame the hidden syndrome as the topic of the talk. However, as the interviewers' response shows they're still occupied with a delivery of a general background on diabetes. The pause following the interviewee's response (l.7) indicates some trouble with its uptake and the next question is framed as extending the inquiry about diabetes rather than pre-diabetic risks (l.10). In ex.1 the interviewee delivered the rates and then aligned with the focus on her scientific study. Here, however, the alarmist stance suggests an attempt by the interviewee to frame the report as a health risk account.

In excerpts 3 and 4, the experts' understanding of the topic differs from or contrasted with that of their hosts. Unlike excerpts 1 and 2, London states his presupposition regarding the incidence or severity of the syndromes. The delivery of assessments will be shown to respond to these presuppositions by redefining relevant syndromes or risk groups. Ex. 3 is part of the opening of a report on a study on mastectomy to prevent breast cancer. The interviewee, who conducted the study, is asked to provide the incidence rate of breast cancer, after the topic is introduced by the interviewer as in a risky ascendance (l.1-4):

ex.3. breast cancer,1.4.10

YL. One of nine wome↑n hh. is expected to become ill with breast cancer (0.4) hhh. it seems to me that the number is ev((en))->the rate of the patients increasing (0.3) hh. >and now it's already one in ↑eight someone told me< (0.3) is that corre:↑ct wha:t (0.3) what is [the rate]

IE. [we↑] see some increa:se (0.2) [not] something e::h very dramatic↓

YL. [yes]

IE. (0.2) hhh. eh::::m (0.2) but ↑especially e:::h (.) what that we e::h (.) see toda↑y is much more awareness (0.2) ↑breast cancer to early ↑detectio:n hhhh. eh tremendous↑ importance (.) for the early detection >to do mammography< (.) with ultra sound hhhh. the↑re is a special group (0.5) of women (0.2) hhh. e::::m who are carriers of a gene↓

(0.5)

YL. Yes-

IE. We call it BRCA (0.5) hhhh. a::nd with ↑these ↑women (0.3) we know that they have >much more breast cancer than the general population they have a risk of between fifty (.) and eighty five percent< hhh. >risk during their life time to become ill with breast cancer or ovarian ↓cance:r (0.4) hhhhh. < and the thing that is ↑unique in this

18 group↑ is that we know how to identify them (0.5) hhhh. and it's possible ↑e:::h to
19 treat the breast cancer they have=

One in nine (heb. *akhat mi'tesha*, l.1), which is presented as the incidence rate, is also the name of an Israeli charity that raises awareness of breast cancer. By suggesting one in nine or eight as the rate (l.2,3) London introduces this ratio as familiar to the audience. When he tries to elicit a confirmation or a more accurate number the interviewee mitigates the presupposed alarm. Her orientation to the alarm rather than the delivery of the rate is evidenced by her responding with a qualitative rather than a numerical assessment ('some increase'; heb. *eizoshehi alyia*, l.5) and by her signifying of awareness as more newsworthy than incidence (l.8-10). Though elicited to confirm or disconfirm numerical information the interviewee topicalizes a particular risk group (identified genetically) rather than breast cancer patients in general (l.14-18).

In ex.4 the interviewee contests the definition of the syndrome and does not deliver the incidence rate. The excerpt is of the opening for an item reporting on a new treatment for melanoma implemented by the interviewee in his oncology ward. As in excerpts 2 and 3 the interviewee treats this exchange as setting the agenda rather than merely an elicitation of background information. However instead of providing incidence rates he redefines the syndrome:

ex.4. melanoma treatment, 9.6.10

1 YL. that is a question that we'll ask you immediately hh. but eh e:h melanoma i::s is a
2 disease e:h (0.4) ((that is)) lethal h. (0.2) and it (.) <u>kills</u> (.) very very fast h. (.) w-
3 >what percentage of the population it ↑affects
4 <u>IE.</u> (0.2) ((head nod signalling no))
5 IE. we talk (.) about the same patients who develop a metastatic melanoma (0.2) hh.
6 YL. yes
7 (.)
8 IE. I::n patients tha:::t the melanoma is only in the first ↑stages (0.2) hh. it's possible to
9 treat ((it)) by an ↑operation a:::nd hhh. only those that develop a ↑metastatic disease
10 go into more aggressive treatments chemotherapy hhh. biotherapy hh. (0.2) <u>these</u>
11 ((are)) (.) the patients tha:t h. (0.4) e:hm e::h for them >[this] treatment is targeted <

London postpones the main topic of the talk (we'll ask you immediately, heb, *mi'yad nish'al othkha,* l.1) and in doing so orients to the delivery of incidence rate as a background issue. However, by marking melanoma as lethal and killing (l.2; heb. *katlanit, me'mita*) he presents this incidence as important for demonstrating the newsworthiness of the treatment. Yet this proposition is negated by the interviewee (l.4) who frames his correction as an agenda setting turn (we talk about; heb, *anakhnu medabrim al*, l.5). Whereas London oriented to the sequence as indicative of the newsworthiness of melanoma in general, the interviewee uses this exchange to focus the discussion on the syndrome he is treating. By evoking broader (ex.2) or narrower risk groups (excerpts 3 and 4) the experts thus used requests for incidence rates – elicited only to give background – as opportunities to reframe or refocus the topic of the talk.

b. Blaming and Defending

In excerpts 1-4, the experts responded to neutral requests for incidence rates and moved rather straightforwardly to delivering these rates or reframing the talk topics. However, on some other occasions the elicitation of risk information was understood to hold the public or the interviewees accountable for these risks or their assessments. As will be shown in excerpts 5 and 6, the experts' responses reflected their understanding of the moral judgment implied in the question. In ex.5, the expert inserts an alarmist scenario whereas in ex.6 the interviewee mitigates the alarming scenario that he understood the interviewers to project. The analysis of excerpts 5 and 6 suggests that the framing of a health risk as a serious threat or as a cause for concern corresponds to who is understood to be accountable for the assessments of the health problem or for raising the alarm.

Ex.5 is taken from an item that promoted an upcoming documentary film about sexually transmitted diseases (STDs) on Channel 10. The interviewee, who appears in the film as well,

is alerting the public to the dangers of STDs by presenting related cancer risks. The excerpt begins with his listing of three types of such cancers and their frequency in individuals with STDs:

ex.5. lethal sex,11.3.10

IE. the second ↑thing >that we know today that we did not know
in the past< (0.3) hhh. is that there is a number of ↑cancers that are caused
by a ↓virus (.) and ↑that's explosive really (.)
because [to] this day we didn't know (.) ((that they)) cause ↑cancer (0.2)
YL. [yes]
IE. hhh. for example cervical cancers with (.) its diverse types hh. is caused
by the papilloma virus the ↑HPV ((eng.)) (0.2) hhh. ↑cancer (.)
of the rectum >apology for this region< yes hhh. and the anal cavity in ninety
percent of the cases↑ is caused by this virus hhh. with cancer
of the ↑<u>mouth</u> (0.6) fifty percent of the cases is caused (.) by
this ↓virus (0.2) hh. [so no:]w that is one major thing
YL. [aha]
IE. that we kno:w of-

This three-part listing has been identified as a form of generalization in various settings including political speeches (Atkinson, 1984), health reports (Potter et al., 1991) and broadcast talk (Hutchby, 2006). When associated with the evaluative expression "that's explosive really" (heb. *veze pzaza mamash;* l.3) this listing indicates that the risk reported is broader than for the diseases actually named. It is clear that the interviewee is on course to raise the alarm when the next question is presented (l.14-17). Whereas the interviewee presents cancer incidence as the proportion of STD infections London elicits the actual incidence for these cancers. The interviewee's response indicates that he understood this shift in formulation as questioning his alert:

YL. Ah what what is the ↑rate of the ↑affecte:d ((persons)) in the population↓
(0.3)
IE. hh. look ((the)) num((bers))-
YL. How prevalent is ↑it
IE. I can tell you (0.2) hh. Israel is one of the sta((tes)) is one of the states where the rate
of cancer of the <u>throat</u> for example is relatively very low between one hundred and
sixty and hundred and eight a year (0.2) hh. cancer of the rectum twice as much three
hundred and sixty hhh. but the numbers are increasingly growing (.) they are
increasingly growing (.) because people bury: their heads in the sand (0.2) hhh.
YL. [°Aha°]
IE. [because to] talk on a sexual disease is not ↑pleasa:nt

The presentation of the rates for throat cancer as "relatively very low" (l.19; heb., *me'od namukh yakhasit*) suggests that the interviewee understands that he may be held accountable for scaremongering. In his response, he contrasts current numbers with their anticipated increase and presents his alarm as necessary "people bury their heads in the sand" (l.22; heb. *anashim tomnim et rosham bakhol*). By using this idiomatic expression the interviewee summarises and terminates the discussion of this topic (Drew & Holt, 1998) and presents his professional judgement as warranting his scenario despite the current low rates. Thus, the delivery of incidences can be seen to respond to the mitigation that London's question was understood to project.

Whereas in ex.5 the interviewee amplified his assessment, the interviewee in ex.6 attenuates the alarm that the interviewer is understood to project. The excerpt is taken from a discussion of a recently published World Health Organization report in which states have been ranked by their incidence of obesity. Towards the end of the opening segment London cites incidence rates for obesity as the newsworthy element of the item (l.1-2). His first "question" (l.2) is presented as a negative assessment of Israel which is ranked in ninth place. Formulated as a declarative statement it invites a confirmation by the interviewee. However, rather than confirming or disconfirming this assessment she responds to the faulting of the Israeli public:

ex.6. obesity report, 26.11.09

YL. ((in)) the third place the United ↑Sta:tes (0.3) some seventy percent have e:h hh. e:h overweight >we are in the eighth pace< hh. (0.4) that is not↑a good place
(1.0)
IE. Should we start with the mitigating circumstances↑ first=
YL. Ye:s
(0.3)
IE. Fo:r thi:::s marvellous ranking (0.2) hh. so e::h first of all eh the demarcation is not in our ↓favour (.) because it demarcates at BMI ((eng.)) above thirty and below
(.)
((7 lines of transcript omitted))
IE. but what happens ↑above thirty >we know that the variance is very very high in the United States [w]e have not reached that at all<

YL. [Aha]
IE. so indeed with us there ((is)) two thirds above BMI ((eng.)) thirty hh. but they do not go over thirty five hh. (0.4) so there are the mitigating circumstances > compared with the countries that are placed much higher where ((they)) reach also forty forty fi[ve< but] we're on our way there=
IE. [hh. bu((t))]
YL. O[: that's it]
IE. [probably]
YL. >That that this is the next question that I wanted what is the graph<

The interviewee can be seen to be setting up her reply as an extended account with the long pause (l.3) suggesting some trouble in providing a more direct response. By requesting to present "the mitigating circumstances" (heb. *ha'nesibot ha'mekilot*, l.4), a vernacular term in Israel taken from legalese, the interviewee couches the issue in familiar language while positioning herself as a (mock) defence attorney. The Hebrew discourse marker (Maschler, 2009) 'first of all' (heb. *kodem kol*; l.7) is used here to secure the floor for the presentation of these circumstances. The key to her "defence" is the explanation of the ranking in terms of BMI (body mass index; l.7-17) where she draws a sharp distinction between the situation in Israel and elsewhere in the world. However, the idiomatic expression "but we're on our way there" (heb. *aval anakhnu baderekh le'sham*; l.17) aligns with the alarming trajectory the question was understood to imply. In fact, London orients to this closure of argument and highlights the trajectory as a newsworthy element (l.19-21). By denoting this trajectory as "the graph" (*heb.* hagraph, l.21) he adopts the scientific perspective on the topic that the interviewee was invited to explain. As in ex.5, the interpretation of the rates is formulated in relation to who is understood to be accountable and for what, when these rates are elicited.

c. Causes and Treatments

Though the experts exploited a variety of opportunities for framing risk assessments or the topics of interviews, their latitude was restricted by the agenda pursued by interviewers

when this information was elicited. In excerpts 5 and 6 interviewers' agendas were implicit and were responded to as such by the interviewees. By contrast, in excerpts 7 and 8 the interviewers can be shown to pursue their agenda explicitly while leaving limited or no space for an alternative frame. These examples illustrate how interviewers could limit or guide the delivery of assessments in ways that aligned with their storyline and the type of information relevant to its construction.

Ex.7 is taken from an item on developmental abnormalities caused by the consumption of a faulty baby formula (Remedia). The interviewee discovered that the cause of these children's abnormalities was the lack of vitamin B1 in this formula. In this excerpt, she presents the results as very significant (l.1) and provides their statistical grounding in detail (l.2-6). The term "significance" (*heb.muvhakut*) is picked up by London as a way of highlighting the risk factor (l.9-10). Though the results are restated rather than questioned, the interviewee hedges them in her response (l.12-25):

ex.7. Remedia affair, 15.11.10

IE. Look at our research the results were very significant because (0.2) the majority most of the children that consumed Remedia hh. e::m we we((re)) (.) we found about eighty to ninety percent of the children with deficiencies e:h linguistic ((ones)) compared with the general population of children that are norm((al)) e::h that did not consume Remedia hh. where it was between e::h five to ten percent that is [the acceptable percentage]

YL. [So so the ↑significance] of the results=

IE. The significance [was]

YL. [indicates] (.) that these children were affected↑ because they did not get ((vitamin)) B1 (0.2) hh. at at during the critical weeks (0.3)

IE. I just want that is co:rrect (0.2) because (0.3) >actually the two groups were identical in terms of a:ge sex a:nd=

YL. Yes

IE. living area and the only difference was that these consumed Remedia and these did not<

MK. What what can be [done]

IE. >[I want] just to qualify that because we did not examine all the children in [this]country

YL. [Yes]

MK. clearly

IE. we examined a group of childre:n (.) some of the parents did not agree to the examination

24 MK. clearly
25 IE. [it could be that the group was selective]<
26 MK. [clearly the the limitations are clear] the (.) question is (0.3) what can be done
27 ↓today for these children

The interviewee explains the significance of her results based on the high prevalence of linguistic deficiencies in children who were fed Remedia (l.1-6). London restates this argument by emphasising the causal link between Remedia consumption, the period of consumption and the observed effects (l.9-10). Though this restatement invites confirmation, the interviewee treats this formulation as incomplete and adds an explanation as to how this finding is statistically significant (l.12-25) and then begins to qualify the claims she is making (l.18-25). By presenting an empirical context the expert aligns with scientific norms of accuracy and accountability (Gilbert & Mulkay, 1984; Armon & Baram-Tsabari, 2016). However, this account was not elicited and by its deliver the interviewee misaligns with the agenda pursued by the interviewers. She manages to qualify her account but she does so while competing for the floor with Kirschenbaum who shifts the topic to "what can be done" (l.17) and marks the hedging as complete and understood (l.21, 26).

The interviewers' control was even more pronounced in the following example where they differ with the interviewee as to what is newsworthy in her account. Ex.8 is taken from the item presented in ex.1. The interviewee is asked to discuss her study of the incidence of cervical cancer among women of North African descent in Israel. The critical finding in this study is that the incidence rate for cervical cancer in this group is higher than the rate for the general population. After she presents the background and rationale for her study (not shown here), London asks her about the cohorts she examined:

ex.8. cervical cancer, 8.12.09
1 YL. daughters of women [from north Africa]
2 IE. °[right right] right°
3 YL. only eh through the lineage ((of)) the mother
4 (0.3)
5 IE. hh. a::h no-
6 YL. did you fi->find a difference between e:h h.

IE. we [could n-]
YL. [women] from mixed origin north [Africa:n]
IE. [we couldn't] [could]n't
YL. [no]
IE. get to such a refinement ((eng.))=
YL. a:h
IE. in this study [((of)) ours]
MK. [but you examined] about a thousand women
(0.3)
IE. °right right°
(0.2)
MK. and what you found actually is tha:t yes=
IE. the finding [remained]
MK. [that means] the f-> =
IE. right =
MK. the finding sho:ws also with the second generation
IE. ri:ght °[true]°
MK. [hh.] and this means what that means that maybe there is he::re
a [hereditary] factor
YL. [a::h]-
MK. but you didn't find it
(0.2)
IE. O.K. [so]
YL. [so] one sec at what difference=
IE. yes

London's question was followed by a series of clarification requests but ones that leave her very little space for replying. Their formulation by interviewers can be seen to respond to their understanding that a hereditary risk factor can explain her results and is the newsworthy element here. London asks about differences in incidence between women from different lineages which the interviewee states is beyond the scope of her study (l.1-13). This response is cut short by Kirschenbaum who elicits and obtains clarifications about cohorts and key finding (l.14-23) but then suggests that a yet unidentified hereditary factor is the cause for observed differences (l.24-27). Her attempts to qualify this statement (l.26, 29) are eliminated by the next clarification request (l.31) with which she aligns (l.32). By using declarative statements and closed questions, the interviewers leave the expert with very limited latitude to contextualize her findings or respond to their queries. Experts' ability to frame their

assessments can be seen to be constrained by what interviewers understand to be relevant and newsworthy in the research or risk reported.

5. Discussion

a. Who is framing

News interviews with experts present a unique challenge for journalists as well as their sources. While journalists often elicit information from experts their framing of this information often differs from the agenda the journalists are setting (Albaek, 2011; Wien, 2014). While some experts have been shown to adapt their language to the media format in which they are interviewed (Fairclough, 1995; Patrona, 2005) others state their unwillingness to "play the media game" (Holland et al., 2012). This study shows that rather than being governed by either journalists or experts (Albaek, 2011; Wien, 2014) opportunities for framing depend on experts' agenda, but also the storyline that journalists pursue and who they hold as accountable for the risks reported or the assessments delivered.

b. Opportunities for framing

In setting the agenda for the interview, the experts exploited similar opportunities as those that journalists tend to use for similar purposes. As shown in sections 4a and 4b, reframing often took place around the delivery of quantitative information in the form of the incidence rates for the syndromes. Journalists have been shown to select quantity formulations (e.g. percentage or precise number), and attribute precision or uncertainty to emphasize the magnitude and severity of syndromes or predict their dangerous rise (Potter et al., 1991; Amberg & Hall, 2010; Collin & Hughes, 2011). This study shows how these and similar forms are captured by experts as opportunities to frame or reframe the risk discussed

or items for which they are interviewed. Experts like journalists treat quantitative information as a rhetorical device (Potter et al., 1991) rather than as a neutral measure of the risk.

c. Social frames, interactional occasioning

Though identified as locally occasioned, experts' frames could well respond to broader discourses concerning the syndromes discussed. For example, the alarmist framing of STDs (ex.5) as compared to the mitigated framing of obesity (ex.6) may respond to conventional media stories about these topics. Whereas obesity tends to be framed as an epidemic and a putative public health crisis (Holland et al., 2011) limited attention has been paid to STDs or their prevention (Pariera, Hether, Murphy, de Castro Buffington, & Baezconde-Garbanati, 2013). Interviewees may have understood their questioning as resonating with general discourses that they, as experts, wanted to challenge. However these contexts should be seen as resources that speakers occasion or challenge rather than as shaping their agendas and responses (Schegloff, 1992; Hutchby, 2006). Even if responses resonate with broader discourses on the syndromes discussed, experts' framing complied with the agendas that the journalists were understood to project where and when their assessments were made.

6. Practical implications

a. Preparation of experts and messages

Experts preparing for interviews about risks are advised to anticipate questions and prepare key messages, connect with common-sense understandings and contextualize alerts by comparison with familiar risks (e.g. Science Media Centre, 2013). Public information officers should state the instructional messages they wish to convey clearly so that these will not get lost in the process of framing when journalists structure the storyline for their audiences (Lariscy, Avery, & Sohn, 2010; Roberts & Veil, 2016). Although advance

preparation for an interview can support the communication of a coherent and clear message, media training should be informed by the interactional dynamics of real-life encounters (Stokoe, 2014) rather than the media realities that experts, or trainers, simulate or anticipate. This study showed that experts may have ample opportunities to shift the agenda and tackle inaccuracies in how topics are framed. But in so doing they need to remain aware of the interview context and what the interviewers identify as relevant when they elicit health risk assessments.

b. Journalists and news-making

The news interview provides journalists with opportunities for critical health reporting. Though some journalists see their roles as disseminators of health information generated by medical institutions, others prime the norms of investigative, even watchdog journalism (Henderson et al., 2014; Gesser-Edelsburg, Mordini, James, Greco, & Green, 2014). Many journalists have developed a sceptical stance towards potential hypes (Hallin, Brandt, & Briggs, 2013), conflicts of interest (Holland, Sweet, Blood, & Fogarty, 2014) or attempts by experts or health institutes to push their agenda (Amend & Secko, 2011; Lariscy et al., 2010). Nevertheless, news-making routines and the limited slots for the science of health reporting often lead to the uncritical copying of experts' press releases (Rim et al., 2014; Sumner et al., 2016). News interviews are not a guarantee against scientific charlatanism and the misinformed reporting that can ensue (Boyce, 2007). However, with their low production costs, interviews can be useful as a follow-up on press reports, by eliciting additional clarifications and holding experts to account for the claims they are making.

c. Traditional and social media

Though public service broadcasters still shape the communication landscape concerning health (Wellcome Trust, 2016) social media have become a key site for the dissemination, sharing and framing of health advice (Abramson, Keefe, & Chou, 2015). Though many researchers distinguish new from "old media" (Natale, 2016) broadcasters and news publishers have increased their penetration into social media platforms by extending their reach and connection with audiences (Kalogeropoulos, Cherubini, & Newman, 2016). A growing number of news and other talk shows are experimenting with the elicitation and incorporation of audience messaging into their dialogues with public figures (Bonini & Monclús, 2015). This study suggests how experts shape their accounts in relation to the agendas that journalists project as relevant and newsworthy. The emerging interfaces between the news and the new media offer new terrains for exploring the co-production of health risk accounts by journalists, experts and their viewers or listeners.

Appendix 1. Transcription Notation

The transcription symbols used in the conversational excerpts are the following:
Speaker turns
YL: Yaron London
MK: Moti Kirschenbaum
IE: Interviewee

Speech delivery
[] mark overlapping speech
A dash (-) marks abrupt cut off, = marks 'latched' utterances
Underlining indicates emphasis
Intervals in and between utterances were measured and are given in small untimed pauses.
(.) marks a pause less or equal to 0.1 seconds.
time marks a pause longer than 0.1 seconds.
.h stands for in-breadths and hh., hhh. for their extension (timed as pauses)
:A colon marks an extension of the sound it follows. A sequence of colons (::) marks longer extensions.
><, <> Mark speech delivery of enclosed words is faster/ slower than surrounding talk
(()) encloses editorial comments.
heb. marks Hebrew transliteration of lexical choices discussed in the text.

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